STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
SCL FINANCIAL CHANGE REQUEST

PERSON INITIATING REQUEST	☐ RESIDENTIAL PROVIDER ☐ COMMUNITY PROVIDER ☐SCL	DATE
CLIENT NAME	DMH ID NO.	MEDICAID? ☐ YES ☐ NO
RESIDENTIAL PROVIDER AND VENDOR NUMBER	MEDICARE? ☐ YES ☐ NO	MEDICAID SPENDDOWN ☐ YES ☐ NO

ONE TIME CONTRACT CHANGES*

ITEM	DATE	JUSTIFICATION	LEGEND*	OTC*	MISC.
* FOR LEGEND MEDICATIONS, ATTACH A COPY OF THE DETAILED PHARMACY BILL. FOR OTC, ALSO ATTACH PHYSICIAN ORDER SHEET OR COPY OF PRESCRIPTION		TOTALS			

ONGOING CONTRACT CHANGES

CONTRACT CATEGORY	AMOUNT	EFFECTIVE DATE	JUSTIFICATION

CHANGES IN INCOME AND BENEFITS

☐ MONTHLY EARNINGS CHANGE	GROSS	NET	EFFECTIVE DATE	EARNINGS CONTRIBUTION
☐ SSI CHANGE ☐ SSDI CHANGE	MONTHLY AMOUNT		EFFECTIVE DATE	
EXPLAIN BELOW OR ATTACH DETAIL ☐ OTHER CHANGE IN INCOME	MONTHLY AMOUNT		EFFECTIVE DATE	

EXPLANATION

FOR DMH USE ONLY CURRENT NAFS SUB-ACCOUNT BALANCE	SAVING (SAV)
	PERSONAL (PRS)
SIGNATURE OF PERSON INITIATING REQUEST	DMH USE ONLY: PAYMENT APPROVED FROM ☐ DMH ☐ SAV ☐ PRS
SIGNATURE OF SCL CASE MONITOR	DMH ADMINISTRATIVE APPROVAL

Financial Change Request Instructions

Complete only sections that apply to the financial change.

- *Date* - Date form initiated.
- *Residential provider and vendor number* - Housing provider with DMH contract and DMH contract number. Medicaid and Medicare information is only required for one time reimbursement of legend, OTC and durable medical supplies.
- *Medicaid* – Indicate if the client currently has Medicaid coverage.
- *Medicare* – Indicate if the client has Medicare coverage.
- *Medicaid spenddown* – Does the client have a Medicaid spenddown?

One Time Contract Changes:

For legend medications, attach a copy of the detailed pharmacy bill. For OTC, also attach physician order sheet or copy of prescription. Medication reimbursement requests must be made within 90 days of purchase. For underutilized apartments, indicate the dates of vacancy under "justification."

- *Item* - Name of item to be reimbursed, i.e. specific medication, security deposit, glasses, hearing aid batteries. May refer to attached detailed receipt.
- *Date* - Purchase date or billing date or service date or date effective.
- *Justification* - Explain why funds need to be from DMH instead of another source.
- *Legend* - Prescription medication cost.
- *OTC* - Over the counter medication cost.
- *Misc*. - Column for cost of item, e.g. shoes, start-up, rent deposit.
- *Total* - Total of each column, legend, OTC, and misc.

Ongoing Contract Changes:

- *Contract category* - e.g. rent, utilities, transportation, personal allowance.
- *Amount* - The amount to be paid monthly on the contract.
- *Effective date* - The date the change is effective.
- *Justification* - Specific reason for request, any information that will help clarify or provide justification for funding of the request, e.g. rent increase, attends community activities and needs transportation funds.

Changes In Income And Benefits:

- *Monthly earnings change* - and earnings contribution - Indicate the net monthly earnings and calculate the client's contribution based on the formula (1 month net earnings - $100)X 40%. For voucher recipients, indicate gross rather than net earnings per month. SCL will calculate the change in client contribution.
- *SSI and SSDI change* - Report changes in benefit income. It is not necessary to report the across the board yearly cost of living changes to Social Security benefits.
- *Other change in income* - Report changes in other benefits and income such as RR retirement, alimony and pensions.

For DMH Use Only:

- *Current NAFS Sub Account Balance Savings (SAV) and Personal (PRS)* - Amounts being held in accounts at the state facility.
- *Payment approved from DMH/SAV/PRS*. Source of payment for requested items.